

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

METHOD AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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REIMBURSEMENT FOR INDIAN HEALTH SERVICE AND TRIBAL 638 HEALTH FACILITIES

Indian Health Service facilities or 638 Tribal facilities will be paid at the most current encounter rate established by the Indian Health Service which is published periodically in the Federal Register for established services provided in a facility that would ordinarily be covered services through the Nebraska Medicaid Program. An encounter includes:

- a. A practitioner visit which may be a:
  - 1. physician, doctor of osteopathy, physician assistant, nurse practitioner, or certified nurse midwife,
  - 2. dentist,
  - 3. optometrist
  - 4. podiatrist,
  - 5. chiropractor,
  - 6. speech, audiology, physical or occupational therapist, or
  - 7. mental health provider such as a psychologist, psychiatrist, licensed mental health practitioner, certified drug and alcohol counselor, or a certified nurse practitioner providing psychotherapy or substance abuse counseling or other treatment with family and group therapy.
- b. Diagnostic services such as:
  - 1. radiology
  - 2. laboratory
  - 3. psychological testing or
  - 4. assessment (mental health)
- c. Supplies used in conjunction with a visit such as dressings, sutures, etc.; and
- d. Medications used in conjunction with a visit such as an antibiotic injection.

Services not included in the encounter rate will be paid at the Medicaid fee for service allowable rate.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

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Payment for Telehealth Services: Payment for telehealth services is set at the Medicaid rate for the comparable in-person service. Tribal Health Clinic Core Services provided via telehealth technologies are not covered under the encounter rate.

Payment for Telehealth Transmission Costs: Payment for telehealth transmission costs is set at the lower of: (1) the provider's submitted charge; or (2) the maximum allowable amount.

The Department reimburses transmission costs for the line charges when directly related to a covered telehealth service. The transmission must be in compliance with the quality standards for real time, two-way interactive audio-visual transmission as set forth in state regulations, as amended.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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OTHER LABORATORY AND X-RAY SERVICES

Anatomical Laboratory Services

For dates of service on or after August 1, 1989, NMAP pays for anatomical laboratory services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
  - a. The unit value multiplied by the conversion factor;
  - b. The invoice cost (indicated as "IC" in the fee schedule);
  - c. The maximum allowable dollar amount; or
  - d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).

The Nebraska Medicaid Practitioner Fee Schedule is effective July 1 through June 30 of each year.

Revisions of the Fee Schedule: The Department reserves the right to adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is:
  - a. Not appropriate for the service provided; or
  - b. Based on errors in data or calculation.

The Department may issue revisions of the Nebraska Medicaid Practitioner Fee Schedule during the year that it is effective. Providers will be notified of the revisions and their effective dates.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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Clinical Diagnostic Laboratory Services

Payment for clinical diagnostic laboratory services is based on the Medicare national fee schedule for clinical laboratory services as established by HCFA to cover the total service (professional and technical components).

X-Ray Services

For dates of service on or after August 1, 1989, NMAP pays a claim for both the technical and professional components of x-ray services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as -
  - a. The unit value multiplied by the conversion factor;
  - b. The invoice cost (indicated as "IC" in the fee schedule);
  - c. The maximum allowable dollar amount; or
  - d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).

The Nebraska Medicaid Practitioner Fee Schedule is effective July 1 through June 30 of each year.

Revisions of the Fee Schedule: The Department reserves the right to adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is:
  - a. Not appropriate for the service provided; or
  - b. Based on errors in data or calculation.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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The Department may issue revisions of the Nebraska Medicaid Practitioner Fee Schedule during the year that it is effective. Providers will be notified of the revisions and their effective dates.

Payment for the professional component only provided to hospital inpatient or outpatient is made according to the Nebraska Medicaid Practitioner Fee Schedule, not to exceed 40 percent of the payment for the total component, as allowed under the fee schedule, for the service provided in a non-hospital setting.

Payment for Telehealth Services: Payment for telehealth services is set at the Medicaid rate for the comparable in-person service.

Payment for Telehealth Transmission Costs: Payment for telehealth transmission costs is set at the lower of: (1) the provider's submitted charge; or (2) the maximum allowable amount.

The Department reimburses transmission costs for line charges when directly related to a covered telehealth service. The transmission must be in compliance with the quality standards for real time, two way interactive audiovisual transmission as set forth in state regulations, as amended.

Transmission costs are not covered when transmission time is negligible. Transmission time is negligible in instances such as, but not limited to, the store and forward transmission of data sent for professional review and interpretation. Transmission time less than 5 minutes for a telehealth service is deemed negligible for Medicaid payment purposes.

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ATTACHMENT 4.19-B  
Item 4a

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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SKILLED NURSING FACILITIES

See Attachment 4.19-D

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) SERVICES

For EPSDT services provided on or after April 1, 1990, the following applies.

For services reimbursed under the Nebraska Medicaid Practitioner Fee Schedule, NMAP pays for EPSDT services (except for clinical diagnostic laboratory services) at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule for that date of service. The allowable amount is indicated in the fee schedule as -
  - a. The unit value multiplied by the conversion factor;
  - b. The invoice cost (indicated as "IC" in the fee schedule);
  - c. The maximum allowable dollar amount; or
  - d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established in the fee schedule).

Payment for clinical laboratory services is made at the amount allowed for each procedure code in the national fee schedule for clinical laboratory services as established by Medicare.

NMAP pays for injections at the wholesale cost of the drug plus an administration fee determined by the Department. Only the administration fee is paid when a physician uses vaccine obtained at no cost from the Nebraska Health and Human Services System.

The Nebraska Medicaid Practitioner Fee Schedule is effective July 1 through June 30 of each year.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

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The Department reserves the right to adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is:
  - a. Not appropriate for the service provided; or
  - b. Based on errors in data or calculation.

The Department may issue revisions of the Nebraska Medicaid Practitioner Fee Schedule during the year that it is effective. Providers will be notified of the revisions and their effective dates.

Other services covered as EPSDT follow-up services will be paid according to currently established payment methodologies, i.e., inpatient hospital treatment for substance abuse treatment services will be paid according to the methodology in Attachment 4.19-A.

Specialized mental health and substance abuse treatment services include day treatment, treatment crisis intervention, treatment foster care, treatment group home and residential treatment center services, provided to children and adolescents under the EPSDT program. Payment rates for specialized mental health and substance abuse services are established on a unit (per day) basis. Rates are set annually. Rates are set prospectively for the annual rate period and are not adjusted during the rate period. Providers are required to submit annual cost reports on a uniform cost reporting form. In determining payment rates, the Department will consider those costs that are reasonable and necessary for the active treatment of the clients being served. Those costs include costs necessary for licensure and accreditation, meeting all staffing standards for participation, meeting all service standards for participation, meeting all requirements for active treatment, maintaining medical records, conducting utilization review, meeting inspection of care, and discharge planning. The Department does not guarantee that all costs will be reimbursed. The submitted cost reports are used only as a guide in the rate-setting process. Payment rates do not include the costs of providing educational services.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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Payment for services provided by JCAHO-accredited facilities will include payment for room and board.

Specialized mental health and substance abuse services provided by state-operated facilities are reimbursed at a rate that includes all reasonable and necessary costs of operation, excluding educational services. State-operated facilities will receive an interim payment rate, with an adjustment to actual costs following the cost reporting period.

Payment for Telehealth Services: Payment for telehealth services is set at the Medicaid rate for the comparable in-person service.

Payment for Telehealth Transmission Costs: Payment for telehealth transmission costs is set at the lower of: (1) the provider's submitted charge; or (2) the maximum allowable amount.

The Department reimburses transmission costs for line charges when directly related to a covered telehealth service. The transmission must be in compliance with the quality standards for real time, two way interactive audiovisual transmission as set forth in state regulations, as amended.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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FAMILY PLANNING SERVICES

For dates of service on or after August 1, 1989, NMAP pays for family planning services and supplies for individuals of child-bearing age at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
  - a. The unit value multiplied by the conversion factor;
  - b. The invoice cost (indicated as "IC" in the fee schedule);
  - c. The maximum allowable dollar amount; or
  - d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).

The Nebraska Medicaid Practitioner Fee Schedule is effective July 1 through June 30 of each year.

Revisions of the Fee Schedule: The Department reserves the right to adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is:
  - a. Not appropriate for the service provided; or
  - b. Based on errors in data or calculation.

The Department may issue revisions of the Nebraska Medicaid Practitioner Fee Schedule during the year that it is effective. Providers will be notified of the revisions and their effective dates.

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## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State NebraskaMETHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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Payment for Telehealth Services: Payment for telehealth services is set at the Medicaid rate for the comparable in-person service.

Payment for Telehealth Transmission Costs: Payment for telehealth transmission costs is set at the lower of: (1) the provider's submitted charge; or (2) the maximum allowable amount.

The Department reimburses transmission costs for line charges when directly related to a covered telehealth service. The transmission must be in compliance with the quality standards for real time, two way interactive audiovisual transmission as set forth in state regulations, as amended.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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PHYSICIANS' SERVICES

For dates of service on or after August 1, 1989, NMAP pays for covered physicians' services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
  - a. The unit value multiplied by the conversion factor;
  - b. The invoice cost (indicated as "IC" in the fee schedule);
  - c. The maximum allowable dollar amount; or
  - d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).

The Nebraska Medicaid Practitioner Fee Schedule is effective July 1 through June 30 of each year.

Revisions of the Fee Schedule: The Department reserves the right to adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is:
  - a. Not appropriate for the service provided; or
  - b. Based on errors in data or calculation.

The Department may issue revisions of the Nebraska Medicaid Practitioner Fee Schedule during the year that it is effective. Providers will be notified of the revisions and their effective dates.

NMAP pays for injections at the wholesale cost of the drug plus an administration fee determined by the Department. Only the administration fee is paid when a physician uses vaccine obtained at no cost from the Nebraska Health and Human Services System.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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Payment for Telehealth Services: Payment for telehealth services is set at the Medicaid rate for the comparable in-person service.

Payment for Telehealth Transmission Costs: Payment for telehealth transmission costs is set at the lower of: (1) the provider's submitted charge; or (2) the maximum allowable amount.

The Department reimburses transmission costs for line charges when directly related to a covered telehealth service. The transmission must be in compliance with the quality standards for real time, two way interactive audiovisual transmission as set forth in state regulations, as amended.

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## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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## METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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PODIATRISTS' SERVICES

NMAP pays for covered podiatry services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
  - a. The unit value multiplied by the conversion factor;
  - b. The invoice cost (indicated as "IC" in the fee schedule);
  - c. The maximum allowable dollar amount;
  - d. For clinical laboratory services including collection of laboratory specimens by venipuncture or catheterization, the amount allowed for each procedure code in the national fee schedule for clinical laboratory services as established by Medicare; or
  - e. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).

Revisions of the Fee Schedule: The Department may adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure or a procedure that was previously identified as "RNE" or "BR" based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is:
  - a. Not appropriate for the service provided; or
  - b. Based on errors in data or calculation.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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Providers will be notified of changes and their effective dates.

NMAP pays for injections at the wholesale cost of the drug plus an administration fee determined by the Department.

Site of Service Limitation: Payment for surgical procedures that are primarily performed in office settings is reduced by 12% when performed in hospital outpatient settings (including emergency departments). NMAP accepts Medicare's determination of surgical procedures that are primarily performed in office settings.

Payment for Telehealth Services: Payment for telehealth services is set at the Medicaid rate for the comparable in-person service.

Payment for Telehealth Transmission Costs: Payment for telehealth transmission costs is set at the lower of: (1) the provider's submitted charge; or (2) the maximum allowable amount.

The Department reimburses transmission costs for line charges when directly related to a covered telehealth service. The transmission must be in compliance with the quality standards for real time, two way interactive audiovisual transmission as set forth in state regulations, as amended.

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OPTOMETRISTS' SERVICES

NMAP pays for covered optometrists' services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
  - a. The unit value multiplied by the conversion factor;
  - b. The invoice cost (indicated as "IC" in the fee schedule) - the provider's actual cost (including discounts) from the provider's supplier. The maximum invoice cost payable is limited to reasonable available cost;
  - c. The maximum allowable dollar amount; or
  - d. For clinical laboratory services including collection of laboratory specimens by venipuncture or catheterization, the amount allowed for each procedure code in the national fee schedule for clinical laboratory services as established by Medicare; or
  - e. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).

Revisions of the Fee Schedule: The Department may adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure or a procedure that was previously identified as "RNE" or "BR" based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is:
  - a. Not appropriate for the service provided; or
  - b. Based on errors in data or calculation.

Providers will be notified of changes and their effective dates.

NMAP pays for injections at the wholesale cost of the drug plus an administration fee determined by the Department.

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Payment for Telehealth Services: Payment for telehealth services is set at the Medicaid rate for the comparable in-person service.

Payment for Telehealth Transmission Costs: Payment for telehealth transmission costs is set at the lower of: (1) the provider's submitted charge; or (2) the maximum allowable amount.

The Department reimburses transmission costs for line charges when directly related to a covered telehealth service. The transmission must be in compliance with the quality standards for real time, two way interactive audiovisual transmission as set forth in state regulations, as amended.

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CHIROPRACTORS' SERVICES

NMAP pays for covered chiropractors' services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
  - a. The unit value multiplied by the conversion factor;
  - b. The invoice cost (indicated as "IC" in the fee schedule);
  - c. The maximum allowable dollar amount; or
  - d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).

Revisions of the Fee Schedule: The Department may adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure or a procedure that was previously identified as "RNE" or "BR" based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is:
  - a. Not appropriate for the service provided; or
  - b. Based on errors in data or calculation.

Providers will be notified of changes and their effective dates.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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Payment for Telehealth Services: Payment for telehealth services is set at the Medicaid rate for the comparable in-person service.

Payment for Telehealth Transmission Costs: Payment for telehealth transmission costs is set at the lower of: (1) the provider's submitted charge; or (2) the maximum allowable amount.

The Department reimburses transmission costs for line charges when directly related to a covered telehealth service. The transmission must be in compliance with the quality standards for real time, two way interactive audiovisual transmission as set forth in state regulations, as amended.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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CERTIFIED REGISTERED NURSE ANESTHETISTS

The Nebraska Medical Assistance Program calculates payment for CRNA/AA services as follows: The total of the units assigned to the CPT/ASA procedure plus the appropriate number of time units are multiplied by the appropriate conversion factor for medically directed or non-medically directed services. This amount must not exceed the amount allowable for physicians' services for the procedure. These services are paid according to the Nebraska Medicaid Practitioner Fee Schedule.

When anesthesia services are provided by an anesthesiologist and a CRNA/AA at the same time, NMAP will make payment only for those services provided by the anesthesiologist.

NMAP does not make additional reimbursement for emergency and risk factors.

NMAP does not make payment for CRNA/AA services for secondary procedures. When multiple surgical procedures are performed at the same time, NMAP pays for only the major procedure.

Payment for Telehealth Services: Payment for telehealth services is set at the Medicaid rate for the comparable in-person service.

Payment for Telehealth Transmission Costs: Payment for telehealth transmission costs is set at the lower of: (1) the provider's submitted charge; or (2) the maximum allowable amount.

The Department reimburses transmission costs for line charges when directly related to a covered telehealth service. The transmission must be in compliance with the quality standards for real time, two way interactive audiovisual transmission as set forth in state regulations, as amended.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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HOME HEALTH SERVICES

The Nebraska Medical Assistance Program pays for medically prescribed and Department-approved home health agency services provided by Medicare-certified home health agencies. The Department may request a cost report from any participating agency.

For dates of service on or after July 1, 1990, NMAP pays for home health agency services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for each respective procedure in the Nebraska Medicaid Home Health Agency Fee Schedule in effect for that date of service.

The Nebraska Home Health Agency Fee Schedule is effective for July 1 through June 30 of each fiscal year.

The Department reserves the right to adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Establish an initial allowable amount for a new procedure based on information that was not available when the fee schedule was established for the current year; and
3. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is:
  - a. Not appropriate for the service provided; or
  - b. Based on errors in data or calculation.

The Department may issue revisions of the Nebraska Medicaid Home Health Agency Fee Schedule during the year that it is effective. Providers will be notified of the revisions and their effective dates.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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Payment for Telehealth Services: Payment for telehealth services is set at the Medicaid rate for the comparable in-person service.

Payment for Telehealth Transmission Costs: Payment for telehealth transmission costs is set at the lower of: (1) the provider's submitted charge; or (2) the maximum allowable amount.

The Department reimburses transmission costs for line charges when directly related to a covered telehealth service. The transmission must be in compliance with the quality standards for real time, two way interactive audiovisual transmission as set forth in state regulations, as amended.

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MEDICAL SUPPLIES, EQUIPMENT, AND APPLIANCES FOR SUITABLE USE IN THE HOME

NMAP pays for covered durable medical equipment, medical supplies, orthotics and prosthetics, at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
  - a. The unit value multiplied by the conversion factor;
  - b. The invoice cost (indicated as "IC" in the fee schedule);
  - c. The maximum allowable dollar amount; or
  - d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).

Revisions of the Fee Schedule: The Department may adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure or a procedure that was previously identified as "RNE" or "BR" based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is:
  - a. Not appropriate for the service provided; or
  - b. Based on errors in data or calculation.

Providers will be notified of changes and their effective dates.

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Transmittal # MS-00-06

Supersedes      Approved MAR 16 2001      Effective JUL 1 2000

Transmittal # MS-93-15

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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PRIVATE DUTY NURSING SERVICES

Payment for approved nursing services will be the lower of:

1. The submitted charge; or
2. The maximum allowable fee as established by the Department.

Payment for Telehealth Services: Payment for telehealth services is set at the Medicaid rate for the comparable in-person service.

Payment for Telehealth Transmission Costs: Payment for telehealth transmission costs is set at the lower of: (1) the provider's submitted charge; or (2) the maximum allowable amount.

The Department reimburses transmission costs for line charges when directly related to a covered telehealth service. The transmission must be in compliance with the quality standards for real time, two way interactive audiovisual transmission as set forth in state regulations, as amended.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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CLINIC SERVICES

NMAP pays for clinic services and outpatient mental health services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
  - a. The unit value multiplied by the conversion factor;
  - b. The invoice cost (indicated as "IC" in the fee schedule);
  - c. The maximum allowable dollar amount; or
  - d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).

The Nebraska Medicaid Practitioner Fee Schedule is effective July 1 through June 30 of each year.

Revisions of the Fee Schedule: The Department reserves the right to adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is:
  - a. Not appropriate for the service provided; or
  - b. Based on errors in data or calculation.

The Department may issue revisions of the Nebraska Medicaid Practitioner Fee Schedule during the year that it is effective. Providers will be notified of the revisions and their effective dates.

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Transmittal # MS 00-06

Supersedes

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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NMAP pays for injections at the wholesale cost of the drug plus an administration fee determined by the Department. Only the administration fee is paid when a physician uses vaccine obtained at no cost from the Nebraska Health and Human Services System.

Payment for Psychiatric Day Treatment Services: Payment rates for psychiatric day treatment services for individuals age 21 and older will be on a unit basis. Rates are set annually for the period July 1 through June 30. Rates are set prospectively for this period and are not adjusted during the rate period. Providers are required to report their costs on an annual basis. Providers desiring to enter the program who have not previously reported their costs or that are newly operated are to submit a budgeted cost report, estimating their anticipated annual costs.

Providers shall submit cost and statistical data on the required form based on the timeframes in 471 NAC 20-003.08. Providers shall compile data based on generally accepted accounting principles and the actual method of accounting based on the provider's fiscal year. Financial and statistical records for the period covered by the cost report must be accurate and sufficiently detailed to substantiate the data reported. If the provider fails to file a cost report as due, the Department will suspend payment. At the time the suspension is imposed, the Department will inform the provider via letter that no further payment will be made until a proper cost report is filed. In setting payment rates, the Department will consider those costs which are reasonable and necessary for the active treatment of the clients being served. Such costs will include those necessary for licensure and accreditation, meeting all staffing standards for participation, meeting all service standards for participation, meeting all requirements for active treatment, maintaining medical records, conducting utilization review, meeting inspection of care requirements, and discharge planning. The Department does not guarantee that all costs will be reimbursed. The cost reporting document is used by the Department only as a guide in the rate setting process. Actual costs incurred by the providers may not be entirely reimbursed.

Psychiatric day treatment centers operated by the State of Nebraska will be reimbursed for all reasonable and necessary costs of operation, excluding educational services. State-operated centers will receive an interim payment rate, with an adjustment to actual costs following the cost reporting period.

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